



What do I do now?

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CASE: WHO AM I?

As medical students, we are given no instructions on the proper way to identify ourselves. Sometimes on rounds, the physicians introduce us to patients as “Dr. So-and-so,” and students are not discouraged from describing themselves the same way.

I even overheard a physician instructing a student to get a history from a patient: “But don’t tell her you are a medical student because she won’t talk to you.” I am uneasy about this less-than-honest self-description, but the practice is common, and when I introduce myself as a medical student, I get the feeling people think my making this distinction is silly or unnecessary.

Commentary: Kate Christensen

What do we call ourselves, when we are not yet physicians, but are caring for patients? Will patients think less of us if we introduce ourselves as students? Will they feel less confident in our care and less likely to follow our recommendations? Every medical student faces this issue at some point in their training. I faced it my first month as a medical student. One of my fellow students passed out his new business cards that said, “Doctor John——” and he urged us to call each other doctor for practice. This bit of deception, even if it is only self-deception, disturbed many of us, and we persuaded him to stop.

The temptation to deceive arose again when we started our hospital duties with patients. We were still students, with no MD after our names, but the physicians supervising us introduced us to patients as “doctors.” Were we to object to this, risking embarrassment for our supervisors and possible reprimand for ourselves? And anyway, after so many years of thankless toil to get where we were, wasn’t it about time we were given a little respect, even if it was a bit premature?

The truth was, most of us secretly liked being called “doctor.” It gave us a taste of the respect and power we knew would soon be rightfully ours.

Are there any legitimate reasons for this deception? One argument is efficiency: when introducing a team of trainees on hospital rounds, it is cumbersome to describe the training status of each individual. Also, most patients do feel more comfortable and comforted in the hands of a physician than those of a student and might be more apt to comply with the treatment plan.

What is wrong with this? From our perspective, very little, aside from some qualms about the slight dishonesty

involved. The problem becomes obvious when we change places with the patient—now how does this slight dishonesty look? I am being introduced to the physician who has my health in her hands, and am informed that she is “Doctor Jones.” I have no reason to think she is not. I have every reason to think she has some experience with my illness, with the medications she is prescribing, and with the tests she is ordering. If and when I find out that she is still years away from even having a license to practice medicine, that she has in fact never treated my illness before, I am apt to feel angry, afraid, and betrayed.

When considered from the patient’s perspective, we can see that the right to know the training status of those providing our care is part and parcel of the informed consent process. Informed consent is not just a form to be signed. It is the process of giving patients all the information relevant to their care—all the information they need to say “yes” or “no” to a given course of therapy. The identities and roles of the members of the care team can be relevant, and patients should have a right to say “no” to this arrangement, as well as a right to agree to it.

Divulging one’s training status can have a direct beneficial effect for the student or resident as well. It can be uncomfortable pretending to be something one is not. Once the patient knows our training status, their expectations are likely to be more in line with what we are in fact able to do. We will then be more comfortable admitting when we do not know the answer or cannot perform a procedure and need to ask for help.

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Commentary: Griffin Trotter

“Who am I?” This is a question we might expect to hear issuing from the bluish lips of an inebriated, chain-smoking existentialist. I believe that, in reality, questions of personal identity constitute a central moral problem for students of medicine.

The circumstances of medical training provide a perfect medium for identity-deficit crisis. In the effort to become physicians, medical students strive to establish a radically new component of personal identity. In the early clinical training years, students are often asked and expected to do the things that doctors do, as if they were, in fact, already doctors. They approach patients in white coats, ask serious questions, and examine exposed flesh. They frequently are expected to generate sophisticated di-



When caring for patients, medical students should be honest about who they are

agnoses and treatment plans and to shamelessly impart medical wisdom to patients. Of course, if they were up to these tasks, they would need no further medical training. Hence, there is fertile ground for an identity crisis.

It may be reassuring or even exhilarating for medical students to introduce themselves as “doctor,” but the practice strongly countervails one of medicine’s core values: honesty. It fails not merely because it is objectionable, but also because it does not succeed in ameliorating the identity crisis. Calling oneself “doctor” is not an effective way of alleviating anxiety about insufficient knowledge or skill. A more likely result is a magnification of feelings of inadequacy and guilt.

Regrettably, the practice of introducing medical students as doctor or pretending that they are physicians is common. This practice is based ostensibly on concern for the well-being and comfort of patients. The assumption that patients will be unable to handle the generally benign presence of medical students is ungrounded and is a classic instance of beneficence twisted into paternalism.

Certainly, some patients will have misgivings about students in certain situations. Often, these misgivings can be overcome with frank discussion. I frequently tell patients that having a medical student involved in their care is a distinct advantage. Because the case load for medical students is much smaller than that for physicians, the patient receives more attention than would normally be available. Often, a diligent student will uncover crucial historical information or pursue fruitful lines of inquiry

just because he or she has the additional time. Meanwhile, double doses of attention are garnered from the physician, who must assess the patient while also addressing the medical student’s assessment. The majority of patients will acknowledge this benefit.

And what if patients staunchly refuse to be examined by students? This situation arises, but it is uncommon. In these situations, it is probably best to excuse the medical students—after explaining the possible disadvantages that patients will suffer under such an arrangement.

Perhaps the practice of deceiving patients about the status of medical students is ultimately motivated more by a desire to avoid discomfort to physicians and students than it is for the benefit of patients. If so, the practice is clearly unjustified. As the testimony of the medical student in our case illustrates, this deception is (and should be) a source of moral anxiety for students. Further, even if students and faculty feel better in the long run when they execute such deceptions, the moral imperative in medicine is primarily to benefit patients. The duty of beneficence, in turn, requires honesty and the cultivation of trust. If a certain amount of embarrassment or other personal discomfort is required to preserve integrity, then so be it.

Authors: Thomasine Kushner and David Thomasma are co-editors of the journal, *Cambridge Quarterly* and the book, *Ward Ethics*, from which this material was adapted with permission of Cambridge University Press. Griffin Trotter is assistant professor of health care ethics and assistant professor of surgery at Saint Louis University Health Sciences Center, St Louis, MO.